

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH

September 5, 1991

COMMISSIONER'S POLICY STATEMENT NO. 68

CROSS REGIONAL PLACEMENTS

POLICY

o In the normal course of events it is expected that hospitalized patients will be discharged back to their DMH Region (and catchment area) of origin. "Region of origin" means that DMH Region in which the patient resided for at least 60 days (1.) prior to hospitalization, or where the patient has familial roots and at least the vestiges of a supportive network of persons or agencies familiar with, and committed to, the patient (2.) -- see below: Guidelines for of Cross-Regional Discharge Prioritizing (p.4).

o The DMH managed service system in the patient's Region of origin is responsible and will be held accountable for providing community support services (psychiatric, case management, residential support, rehabilitative, acute inpatient, etc.) that will allow the patient a reasonable opportunity to reestablish herself or himself in community based living upon discharge.

o The hospital treatment team is responsible and will be held accountable for assessing the patient's needs for the purposes of discharge planning, communicating those needs to the community-based representatives of the Department's managed service system in the Region of origin, and arranging for sufficient visits to discharge placement sites so that the patient can reasonably be expected to adapt to his or her new circumstances. In no case is placement in the Middletown Health Care Center (MHCC) to be considered a resolved discharge disposition; this means that the hospital treatment team and the outpatient case management team are expected to create a long term plan within which the objectives of the temporary MHCC placement are clearly delineated.

o The Regional Director of the patient's Region of origin is responsible and will be held accountable for facilitating and guaranteeing the active collaboration of representatives of that Region's managed service system with the hospital treatment team in pursuing discharge planning in a timely and proactive manner. Discharge planning includes arranging for conjoint treatment team meetings, engaging the patient and informing him or her about community resources that are available, arranging visits so the patient can become familiar (or reestablish familiarity with)

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both the community and its resources, and facilitating the reestablishment of familial ties and/or relationships with other individuals or groups who are important to the patient.

o Similarly, the Superintendent or Chief Executive Officer of the hospital is responsible and will be held accountable for guaranteeing the hospital staff's participation in these discharge-related activities -- and also for assuring that significant effort and creativity has been invested by the hospital staff in laying the groundwork for a suitable discharge of the patient back to his or her Region of origin (e.g., involving the family and/or significant others in the patient's discharge planning from the beginning of that process). It is expected that discharge planning will commence prior to or immediately upon the patient's admission.

o Nevertheless, in spite of these activities, it is possible that a hospitalized patient will decide to reside in a Region (or Catchment Area) other than that of his or her of origin. ULTIMATELY, THE PATIENT HAS THE RIGHT TO DECIDE IN WHICH COMMUNITY SHE OR HE WILL LIVE -- and all DMH personnel and grantee agencies are expected to act in good faith to help the patient achieve his or her goals and objectives.

o In considering the ultimate Region or Catchment Area to which a hospitalized patient will be discharged, each case must be considered on its own merits and be decided principally in terms of the patient's clinical needs, special needs, and personal wishes. Particular patient characteristics (e.g., the patient is dually diagnosed [MICA] or under the authority of the PSRB) shall not prejudice the patient's chances of being accepted into the services of the Region where she or he desires to live -- and arbitrary restrictions by providers with regard to such personal characteristics are not acceptable. In all cases it is expected that the Region of destination's managed service system will provide those services that will afford the patient a reasonable opportunity to (re)establish himself or herself in community based living upon discharge.

PROCEDURES

o Both region-based managed service system staff and hospital staff will be provided with ongoing staff development activities to increase their knowledge about, and ability to provide, clinically responsible discharge planning.

o Each DMH Region will focus QA monitors on cross-regional discharge referrals and discharges in order to inform the development of future policies and procedures in this matter.

o All cases in which an individual does not wish to return to his or her Region of origin upon discharge will be reviewed

individually, and will be resolved in accordance with the Guidelines for Cross-Regional Discharge Prioritizing articulated below (p.4).

- o In all cases in which cross-regional discharges are being planned, the hospital treatment team is expected to notify the Regional Directors of the patient's Region of origin and of the Region to which the patient is being discharged.

- o As long as the patient is on an extended leave of absence or until 60 days have elapsed after discharge, if hospitalization is necessary the patient will be hospitalized at the hospital from which the discharge was made. After that, the new Region will be considered the Region of origin and the patient will be hospitalized in whatever hospital covers that community (3.).

- o It is expected that, for the most part, the Regional Directors immediately involved in cross-regional referrals will resolve the matter between them as necessary without need for further review.

- o A standard, state-wide process will govern the disposition of those cross-regional discharges that the regional directors involved were unable to resolve themselves. The following process is to be used:

- The two Regional Directors involved, if they are unable to resolve a cross-regional discharge referral, will arrange for the scheduling of a case conference.

- The case conference will be presented to a DMH Cross Regional Referral Committee. This Committee will be chaired by the DMH Deputy Commissioner for Clinical Services and will further consist of the DMH Chief, Affirmative Action and Patients' Rights plus one other staff member from the Office of the Commissioner, one DMH Regional Director from an uninvolved Region appointed for each case by the DMH Deputy Commissioner for Clinical Services, and one hospital Superintendent or Chief Executive Officer from an uninvolved hospital appointed by the DMH Deputy Commissioner for Clinical Services for each case. The decision by this Committee is binding on all parties, unless they wish to appeal the decision to the Commissioner of the Department.

- o A small pool of funds will be set up to support the buttressing of services for an anticipated 3-4 cases per year in which cross-regional referrals impose extra burdens on the receiving Region's managed service system. It will be up to the DMH Cross Regional Referral Committee to award such funds to a receiving Region upon deciding a case of cross-regional referral.

o Each hospital Superintendent or Chief Executive Officer is requested periodically to conduct a careful review of those patients who desire cross-regional discharges so as to confirm or update data regarding these patients' discharge readiness status: under 90 days, 90 days to 1 year, over 1 year. Based on these data, the Office of the Commissioner will then develop a final grid on which the number of cases that will be ready for discharge within 90 days will be highlighted. Upon completion of this task, the above procedures will be implemented and the discharges will proceed.

Guidelines for of Cross-Regional Discharge Prioritizing

HIGHEST WEIGHT

- o Patients' wishes ultimately must determine where they will reside after discharge.
- o For usual discharge planning purposes, it will be assumed that patients will return to their Regions of origin. This will hold unless a patient expresses different wishes or other countervailing factors indicate another plan would be better.
- o Clinical assessment of the patient's resource needs and the availability of services essential to the patient's functioning may determine a discharge plan to a destination other than the Region of origin.

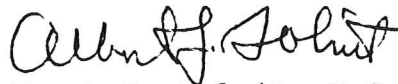
SOME WEIGHT

- o Fiscal resource issues in the Region of Destination vis-a-vis the Region of origin.
- o "Balance of Payments" between and among Regions -- as much as possible, cross-regional referrals should balance out among Regions. (The existence, as identified by quantifiable QA measures undertaken by the Regional Offices, of statistically significant asymmetry in movements across regions will be addressed when necessary at the Regional Directors Meeting.)
- o The fact that the patient has, through a long and well documented history of objectionable and/or dangerous behavior, has engendered such ill will in the Region of origin so as to severely compromise that Region's ability to assure the provision of necessary services.

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FOOTNOTES

1. This conforms to the Connecticut State Department of Income Maintenance General Assistance Policy Manual, Chapter I, page 6, par. 2b: "An institutionalized person is to be considered a resident of his/her town of origin (the town in which he/she lived at the time of institutionalization) during the period of institutionalization and for 60 days following discharge."
2. Consult Commissioner's Policy no. 37 of May 1, 1987, par. 2: "It is therefore the Department of Mental Health's policy that admissions to inpatient services should occur in the Department of Mental Health facility serving the client's local community."
3. With regard to placements in skilled nursing facilities, this supersedes the Commissioner's Policy Statement no. 14, par. 7 of November 1, 1983.



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Commissioner